CHAPTER III – CARRIER BILLING

OBJECTIVE

This chapter provides participants with an overview of the carrier claims billing changes and processing system under the ambulance fee schedule.

NEW CODING REQUIREMENTS

The implementation of the ambulance fee schedule has generated new coding requirements for carrier claims. The following are the concepts from the ambulance fee schedule that require changes in coding claims:

1. Seven categories of ground ambulance services;
2. Two categories of air ambulance services;
3. Payment under the fee schedule is based on the condition of the beneficiary, not on the type of vehicle. However, during the transition period the reasonable charge portion of the blended payment is based on the vehicle used except under the following circumstances; (1) ALS vehicle used, emergency transport; No ALS service furnished; and (2) ALS vehicle used, non-emergency transport, No ALS service furnished; and (3) an emergency response.
4. Payment is determined by the point of pickup which is reported by the five-digit zip code;
5. Increased payment for additional rural ground miles. (BIPA §221)
6. New HCPCS codes are effective for dates of service beginning January 1, 2001. The exception to this are codes Q3019 and Q3020 which are effective April 1, 2002.
7. No grace period for old HCPCS codes for dates of service after January 1, 2001. There is an exception for suppliers using Methods 3 and 4 who may continue to use the HCPCS codes for items and services, including J codes and CPT codes for EKG testing, during the transition period. Also, there is an exception for mileage codes A0380 and A0390 from January 1, 2001, until April 1, 2002. After the fee schedule has been implemented, all ground mileage should be billed as A0425. HCPCS codes A0380 and A0390 will be invalid beginning April 1, 2002.
8. Services and supplies included in the base rate except for methods 3 and 4; and
9. Beginning April 1, 2002, assignment is mandatory for all ambulance claims (specialty 59). This means that suppliers may not bill or collect from the beneficiary any

amount other than any unmet Part B deductible and Part B coinsurance amounts.

- If a claim is submitted as unassigned, convert the claim to assigned.

- If a claim is submitted as unassigned and has some dates of service prior to the April 1, 2002, transition, and other dates of service on or after that date, split the claim. Convert the portion of the split claim with the date of service on or after April 1, 2002 to assigned.

Use Remittance Advice Remark Code N71. The present wording of Remark Code N71 will be modified to read, "Your unassigned claim for a drug or biological, clinical diagnostic laboratory services or ambulance service was processed as an assigned claim. You are required by law to accept assignment for these types of claims."

10. Multiple Billing Methods

Effective for dates of service on or after April 1, 2002, with the implementation of the fee schedule, carriers must ensure that each supplier uses only one billing method. In the absence of an election, carriers should convert the suppliers using multiple billing methods to Method 2.

CLAIM CODING GUIDELINES

Coding Instructions For The HCFA-1500 Claim Form

1. On April 1, 2002, there are two new HCPCS codes that can be used during the transition period only. Once we have transitioned to a full fee schedule payment, these codes will no longer be valid for dates of service that begin with the full fee schedule implementation date.

   ALS VEHICLE USED, EMERGENCY TRANSPORT, NO ALS SERVICE FURNISHED

   During the transition period, if an ALS vehicle is used for an emergency transport but no ALS level service is furnished, use code Q3019.

   ALS VEHICLE USED, NON-EMERGENCY TRANSPORT, NO ALS SERVICE FURNISHED

   During the transition period, if an ALS vehicle is used for a non-emergency transport and no ALS level service is furnished, use code Q3020.

2. There will be no grace period to transition the use of the new HCPCS codes. Claims that are submitted with the old HCPCS codes for dates of service January 1, 2001, or later will be returned as unprocessable. There is an exception for suppliers using Methods 3 and 4 who may continue to use the HCPCS codes for items and services, including J codes and CPT codes for EKG testing, during the transition period. Also, there is an exception for mileage codes A0380 and A0390 which are valid through March 31, 2002. Beginning with services furnished on April 1, 2002, all ground mileage must be billed using A0425.

   To establish a reasonable charge for the blended payment during the transition period for HCPCS A0425, develop a simple average (not a weighted average) of the 2001 reasonable charge allowances for HCPCS codes A0380 and A0390 per PM AB-00-88. Use that average updated with the Ambulance Inflation Factor (see PM AB-01-22).

1. Suppliers using Methods 3 and 4 may use supply codes A0382, A0384, and A0392-A0999, as well as J codes and CPT codes for EKG testing, during the transition period.
2. Claims must contain the five-digit zip code of the point of pickup.

    - On the HCFA 1500, use box 23.

    - Electronic billers using **X-12N 837** (4010) are to report the origin information in loop 2310D(Service Facility Location). NM1 is required. MN101 will have the value “77” (Service Location) and NM102 will have the value “2” (Non-Person Entity). The remaining fields are not required. N2 is not required. N3 (Service Facility Location Address) is used to report address information. N4 (Service Facility Location City/State/ZIP) is required. N401 is used to report city name, N402 is used to report the State Code and N403 is used to report the zip code.
    - Electronic billers using **National Standard Format** (NSF) are to report the origin information in record EA1. EA1-06 is address information (optional), EA1-08 is city name (optional), EA1-09 is state code (optional), EA1-10 is zip code (**required**).

3. Since the zip code is used for pricing, more than one ambulance service may be reported on the same claim for a beneficiary only if all points of pickup are located in the same zip code. Suppliers must prepare a separate claim form for each trip if the points of pickup are located in different zip codes.
4. A claim without a zip code or with multiple zip codes will be returned as unprocessable.
5. Generally, each ambulance trip will require two lines of coding: one line for the service and one line for the mileage. Suppliers who do not bill mileage (for example, paramedic intercept suppliers), would have one line of coding for the service. Suppliers affected by BIPA 423 should bill mileage.
6. When mileage is billed, the miles must be whole numbers. If a trip has a fraction of a mile, round up to the

nearest whole number. If it is less than one mile, code one mile.

7. The following values **must be used** in combinations of two in order to form a two-position modifier. The modifier must indicate both origin and destination. For example, if the origin is the patient's home and the destination is a hospital the modifier would be RH; if the origin is a hospital and the destination is a nursing home, the modifier would be HE.

    - The first position alphabetic value is used to report the origin of service.

    - The second position alphabetic value is used for the destination of service.

    - The origin/destination codes are defined below:

    D Diagnostic or therapeutic site other than P or H
    E Residential, domiciliary, custodial facility (nursing home, not skilled nursing facility)
    G Hospital-based dialysis facility (hospital or hospital-related)
    H Hospital
    I Site of transfer (for example, airport or helicopter pad) between modes of ambulance transport
    J Non-hospital-based dialysis facility
    N Skilled Nursing Facility (SNF)
    P Physician's office (includes HMO non-hospital facility, clinic, etc.)
    R Residence
    S Scene of accident or acute event
    X Intermediate stop at physician's office enroute to the hospital (includes HMO non-hospital facility, clinic, etc.)

Coding Guidelines for the HCFA-1491

With the implementation of the ambulance fee schedule, there are two new HCPCS codes that can be used during the implementation period only. Once we have transitioned to a full fee schedule payment, these codes will not longer be valid for dates of service that begin with the full fee schedule.

ALS VEHICLE USED, EMERGENCY TRANSPORT, NO ALS SERVICE FURNISHED

During the transition period, if an ALS vehicle is used for an emergency transport but no ALS level service is furnished, use code Q3019.

ALS VEHICLE USED, NON-EMERGENCY TRANSPORT, NO ALS SERVICE FURNISHED

During the transition period, if an ALS vehicle is used for a non-emergency transport and no ALS level service is furnished, use code Q3020.

1. There will be no grace period to transition the use of the new HCPCS codes. Claims submitted with old HCPCS codes for dates of service January 1, 2001 and later will be returned as unprocessable. The exception are those HCPCS codes for items and services that Methods 3 and 4 billers may continue to bill during the transition , and for mileage codes A0380 and A0390 which are billable through March 31, 2002. On and after April 1, 2002, all ground mileage should be billed as A0425. HCPCS codes A0380 and A0390 will be invalid for service on or after April 1, 2002.

   To establish a reasonable charge for the blended payment during the transition period for HCPCS A0425, develop a simple average (not a weighted average) of the 2001 reasonable charge allowances for HCPCS codes A0380 and A0390 per PM AB-01-185. Use that average updated with the Ambulance Inflation Factor (see PM AB-01-22).

2. Generally, a claim for ambulance service will require two entries: one HCPCS code for the service and one HCPCS code for the mileage. Suppliers who do not bill mileage would have an entry only for the service. Suppliers effected by BPIA 423 should bill mileage.
3. Box 14 should contain the HCPCS mileage code, as well as the number of loaded miles.
4. If mileage is billed, the miles must be in whole numbers. If a trip has a fraction of a mile, round up to the nearest whole number. If the trip is less than a mile, code one mile.

5. Suppliers using Method 3 or 4 may use supply codes A0382, A0384, and A0392-A0999, as well as J codes, and CPT codes for EKG testing, during the transition period. These supply codes should be entered in box 22. Method 1 and Method 2 claims should be denied.
6. The zip code of the point of pickup must be entered in box 12. If a zip code is not entered in box 12 or there are multiple zip codes entered, the claim will be returned as unprocessable.
7. The following values **must be used** in combinations of two in order to form a two-position modifier. The modifier must indicate both origin and destination. For example, if the origin is the patient's home, and the destination is a hospital, the modifier would be RH; if the origin is a hospital, and the destination is a nursing home, the modifier would be HE, etc.

    - The first position alphabetic value is used to report the origin of service.
    - The second position alphabetic value is used for the destination of service.
    - The origin/destination codes are defined below.

    D Diagnostic or therapeutic site other than P or H
    E Residential, domiciliary, custodial facility (nursing home, not skilled nursing facility)
    G Hospital-based dialysis facility (hospital or hospital-related)
    H Hospital
    I Site of transfer (for example, airport or helicopter pad) between modes of ambulance transport
    J Non-hospital-based dialysis facility
    N Skilled Nursing Facility (SNF)
    P Physician's office (includes HMO non-hospital facility, clinic, etc.)
    R Residence
    S Scene of accident or acute event
    X Intermediate stop at physician's office enroute to the hospital